Enrollment Guide

Retirees / Plan Year 2008

Benefit Services Division

Benefit Options

Choice. Value. Health.

TABLE OF CONTENTS

INTRODUCTION

Benefit Options, the State of Arizona's comprehensive employee and retiree benefits package, was designed with you and your family in mind. You will notice more of an emphasis on wellness this year, because the Employee Wellness Program is one of your most important health benefits as a State retiree. We want to help you be well today and stay well for life.

The Benefit Options Guide is designed to provide an overview of the Benefit Options Program and the benefits offered through the State of Arizona. The actual benefits available to you and the descriptions of these benefits are governed, in all cases, by the relevant Plan Descriptions and contracts. In the event of discrepancies between this Guide and relevant Plan Description or contracts, including amendments to the contract, plan descriptions shall prevail. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.

In this valuable reference guide, we have included explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. This document is no longer just an enrollment guide; it is a resource to use throughout the year for services and benefits provided to you as a State of Arizona retiree. In this guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

Remember: Independent of the Benefit Options program, sponsored by the Arizona Department of Administration (ADOA), the Arizona State Retirement System (ASRS) also offers a comprehensive benefits package through SecureHorizons. Both plans will be effective January 1, 2008. The two plans are not affiliated. If you choose medical and dental coverage through the ASRS program, you will not be allowed to maintain or reelect coverage with ADOA.

How to Use This Guide

The Benefits Guide is divided into chapters, each covering a specific benefits program or important information. These programs include:

- Employee Wellness
- Medical Plans
- Pharmacy Benefits
- Dental Plans
- Vision Plans
- COBRA

IMPORTANT CONTACT INFORMATION

Contact	Phone Number	Web Address	Policy Number
Medical Plans			
Fiserv Health - Harrington Benefits (Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson Healthcare)	1.888.999.1459	www.myazhealth.com	3J
TDD/TTY	1.866.503.3463		
UnitedHealthcare	1.800.896.1067	www.myuhc.com	705963
TDD/TTY	1.888.697.9055		
SecureHorizons	1.866.622.8055	www.pacificare.com/adoa	
TTY	1.888.685.8480		
Blue Cross Blue Shield (NAU Retirees only)	1.800.423.6484	www.bcbsaz.com	
Pharmacy			
Walgreens Health Initiatives	1.866.722.2141	www.mywhi.com	512298
BCBS Pharmacy Plan (NAU Retirees only)	1.800.423.6284	www.bcbsaz.com	
Dental Plans			
Delta Dental	1.800.352.6132	www.deltadentalaz.com	7777-0000
Employers Dental Services	1.800.722.9772	www.mydentalplan.net	6300
Assurant Employee Benefits	1.800.443.2995	www.assurantemployeebenefits.com	EA82
MetLife Dental	1.800.942.0854	www.metlife.com/dental	94739
Vision Plan			
Avesis, Inc.	1.800.828.9341	www.avesis.com	10790-2075
Flexible Spending Accounts			
ASI - InfoLine	1.800.366.4827	www.asiflex.com	
ASI - Member Services	1.800.659.3035	email: asi@asiflex.com	
Life and Short Term Disability Plans			
Standard Insurance Company	1.866.440.4846	www.standard.com/mybenefits/arizona/	617950
Long Term Disability			
VPA (ASRS participants)	1.818.591.9444	www.vpainc.com	
Standard Insurance Company (PSPRS, EORP, CORP, OPT RET Participants)	1.866.440.4846	www.standard.com/mybenefits/arizona/	
Retirement Systems			
Arizona State Retirement System (ASRS) 3300 N. Central Ave, 13th Floor Phoenix, AZ 85012	602.240.2000 or 1.800.621.3778	www.asrs.state.az.us	
Public Safety Personnel Retirement System (PSPRS) and Elected Officials' Retirement Plan (EORP); Corrections Officer Retirement Plan (CORP) 3010 E. Camelback Rd, #200 Phoenix, AZ 85016	602.255.5575	www.psprs.com	
Other Important Numbers			
Benefit Options Wellness	602.771.WELL	www.benefitoptions.az.gov/wellness/ email: wellness@azdoa.gov	
ADOA Benefits Office 100 N 15th Ave #103 Phoenix, AZ 85007	602.542.5008 or 1.800.304.3687	www.benefitoptions.az.gov email: azboquestions@azdoa.gov	

EMPLOYEE WELLNESS

Being healthy one moment is one thing. Staying healthy over the long run is yet another…

The State of Arizona values your health. The Wellness Program's goal is to provide services that assist in creating healthy lifestyles, detecting health issues early and managing existing conditions.

This is why one of the most important benefits for State retirees is the Benefit Options Wellness Program. The Wellness Program offers State retirees, and in some instances their families, health education, screenings and more.

In the last year, Wellness has provided over 650 worksite classes and screenings with almost 14,000 participants. The Wellness Program also provided 16,971 influenza vaccinations to employees, retirees and their families in 2006's flu season.

An addition to the Wellness Program this year is the Mayo Clinic Health risk Assessment (HRA), which allows you to become knowledgeable about your health and provides free Mayo Clinic Lifestyle Coaching to help retirees make healthy changes. During the 2008 HRA campaign, you can log on, complete the questionnaire, and manage your health.

Wellness services are available at low or no-cost and are provided by contracted professionals who will travel across Arizona providing retirees with health education or screening services.

The Wellness Program offers:

- Health education classes focusing on physical activity, nutrition, stress management, chronic diseases and more
- Weight Watchers at Work – 10-week sessions
- Mini-health Preventative screening (cholesterol, blood pressure, body composition, blood glucose, optional osteoporosis and prostate specific antigen).
- Mobile Onsite Mammography –mammograms at worksites across Arizona. These results are sent directly to your physician.
- Skin cancer screening
- Onsite chair massage
- Annual flu vaccine program beginning in the fall each year

To see what is scheduled in your area, or for additional information and a complete list of services, visit the website at *www.benefitoptions.az.gov/wellness* (also available through *www.yes.az.gov*).

Other Wellness Services include:

- Monthly Newsletter (wellNEWS) – this electronic newsletter can be viewed on the Wellness website each month at *www.benefitoptions.az.gov/wellness*.
- Wellness Program Website – the website provides many online resources including the monthly newsletter, and monthly Wellness events scheduled throughout the state.
- More to come – look for more programs and services coming from the Wellness Program throughout the year by visiting *www.benefitoptions.az.gov/wellness*

What people are saying about the services of the Wellness Program:

Wellness Services – "Thank you so much for your help setting up Wellness events for our agency. The Wellness Program has given us great service and our employees are enjoying the programs that come out of your office."

Mobile Mammography – "If MOM hadn't been available at work, I wouldn't have gotten a mammogram. I don't want to take time off work to get it done, so it's nice I could do it right at work and it only took 15 minutes!"

Mini-Health Screening – "I was unaware that my cholesterol and blood pressure was high. This screening was a wake up call for me to see my Doctor and starting living healthier. Thank you!"

Skin Cancer Screening – "Had it not been for the cancer screening (and my nagging yet wonderful husband) I could be in some serious trouble now and possibly facing chemotherapy. Thank you, thank you for providing this valuable service to state employees and their families. I urge anyone who even thinks they would like confirmation that the spot on their arm, leg or wherever, is just a mole or freckle to make an appointment and participate in the screening. It really is worth the time."

Weight Watchers – "I am so happy that a co-worker asked me to attend. This is great … at work and sharing stories with new friends especially our coach! In the past 6 weeks I've lost 10 pounds and feel great! Thanks again for the support of the state to link with this great program."

Weight Watchers – "I have lost 70 lbs. so far. I used to walk down the hall and not even look up at people, because I felt so uncomfortable. Now with more confidence I hold my head up and look people in the eye as I go down the hall. It's important to keep busy to avoid eating out of boredom. One thing I do to keep my hands busy at home is crochet."

Benefit Options Wellness is here to help you be well today and stay well for life.

ADOA
Benefit Options Wellness
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007

602.771.WELL (9355)
Toll free: 800.304.3687
Email: wellness@azdoa.gov
Website: www.benefitoptions.az.gov/wellness

Programs for SecureHorizons Members

SecureHorizons SilverSneakers Fitness Program
As the nation's leading exercise program designed exclusively for older adults, SilverSneakers includes a basic fitness center membership, specialized SilverSneakers classes, Senior Advisor assistance and much more! SilverSneakers is available to SecureHorizons' ADOA Medicare eligible members. For a list of participating fitness centers, log on to *www.silversneakers.com* or call 1.888.423.4632.

If you live in an area that does not have a participating fitness center, increase your physical activity by joining SilverSneakers Steps, a self-directed, pedometer-based walking and exercise program. SilverSneakers Steps empowers you to take responsibility for your own health by providing the tools, equipment, communication, incentives and motivation necessary to help you achieve a healthier lifestyle through increased physical activity. For more information, log on to *www.silversneakers.com* or call 1.888.423.4632.

SecureHorizons' Solution for Caregivers Program

Are you a Caregiver?

Do you care for a loved one or does someone care for you?

- Do you help your spouse or need help with daily tasks such as bathing, dressing or taking medication?
- Do you help your parent get to and from the drugstore or doctor's office?
- Are you concerned that your loved one or you may not be able to remain independent?
- Do you feel overwhelmed, alone and don't know where to turn for help?

If you are one of 44 million Americans who is a caregiver or if someone is caring for you, Evercare™ Solutions for Caregivers can help. To learn more about our personalized approach to caregiving and how it may benefit you and your loved one, call 1-800-610-2660, or for the hearing impaired, 1-800-387-1074, 8 a.m. to 8 p.m. MST, Monday through Saturday.

BENEFITS ELIGIBILITY

The following persons are eligible to participate in the Arizona Benefit Options program:

- Retirees receiving a pension under a state-sponsored retirement plan and continuing enrollment in the Retiree health, dental, or vision plan.
- Long-Term Disability (LTD) participants collecting benefits under a state-sponsored plan.
- Eligible former elected officials and their qualified dependents if the elected official has at least 5 years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
- Surviving spouses and qualified dependents provided they were covered at the time of the Retiree's death.
- Surviving spouses of former elected officials provided they were covered at the time of the official's death.

As an eligible Retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).

If you have declined or cancelled ADOA's medical and/or dental coverages in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverages during the Open Enrollment period.

If you have a qualified dependent that is not currently enrolled in Arizona Benefit Options, he or she may be added during the Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment, unless there is a Qualified Life Event (QLE). You have 31 days from the QLE to change your enrollment through the ADOA Benefits Office. The change must be consistent with the event.

Eligible dependents include:

- Your legal spouse
- Natural, adopted and/or stepchildren under age 19, or under 25 if a full-time student at an accredited educational institution*
- Natural, adopted and/or stepchildren who were disabled prior to age 19 as defined by Social Security Administration (SSA) guidelines
- Children placed in the retiree member's home by court order pending adoption
- Minors under the age of 19 for whom the retiree or legal spouse has court-ordered guardianship
- Foster children under the age of 18

Please note: If your dependent child is approaching age 19 and is disabled, immediately contact your ADOA Benefit Services Division regarding the procedures to continue coverage for this dependent child. You will need to provide verification that your dependent child has a qualifying permanent disability in accordance with Social Security Administration (SSA) guidelines that occurred prior to his or her 19th birthday. Documentation may be required periodically to maintain a dependent on your plan. Disability eligibility and continued coverage will be determined by the plan administrator.

* See Plan Description for “full-time student” information.

Dependent Documentation Requirements
If you are enrolling a spouse or dependent whose last name is different from your own, the dependent’s coverage will not be processed until supporting documentation, such as a marriage license (for a spouse), birth certificate, or court order (for dependents), is provided to the ADOA Benefit Services Division office. Subsequent verifications may be requested by plan administrators. If there is a delay in locating required documents, please contact the ADOA Benefit Services Division. Coverage will be suspended until all the necessary documents have been received.

Qualified Medical Child Support Order (QMCSO)
If a QMCSO exists, you must elect and continue coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO. If you terminate coverage, ADOA will reinstate coverage retroactive to the date coverage was terminated. You will be responsible for any past due premium.

CHANGING YOUR BENEFITS

You may only change your benefit elections during the year when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next annual open enrollment period to make benefit changes.

Qualifying Life Events include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse;
- Changes in dependent status: birth adoption, placement for adoption, death, or dependent eligibility due to age, marriage, student status;
- Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependent;
- Changes in residence that result in different available plan options.

Refer to the plan description book.

Timeframe to Submit a Change Request
Requested benefit changes must be submitted in writing to ADOA Benefit Services Division within 31 calendar days of the event.

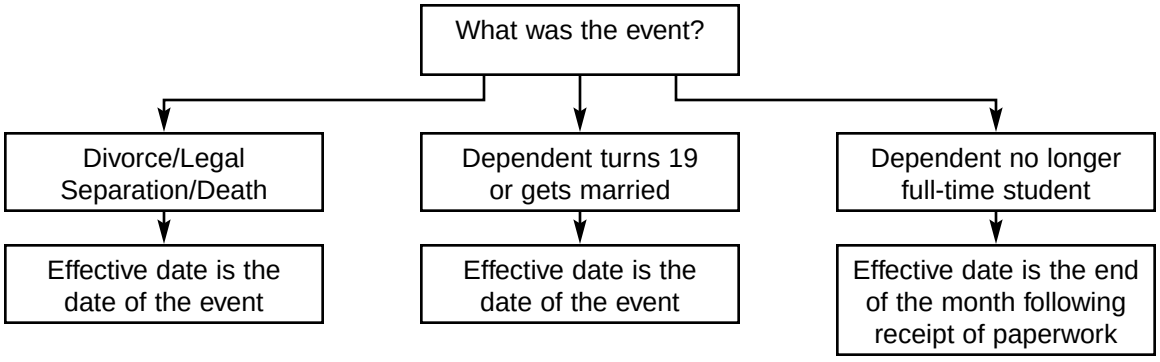
Effective Date of the Change
The effective date for benefit changes resulting from birth, adoption, or placement for adoption is the date of the event. The effective date for benefit changes based on all other QLEs is the first day of the next calendar month, following the date the retiree submits the requested change, in writing, to ADOA Benefit Services Division. Please consult with ADOA Benefit Services Division to determine whether or not the life event you are experiencing qualifies under the regulations.

Premium Changes Due to QLEs
Any change in premiums due to a QLE will be in effect the 1st of the month following the receipt of all QLE documentation.

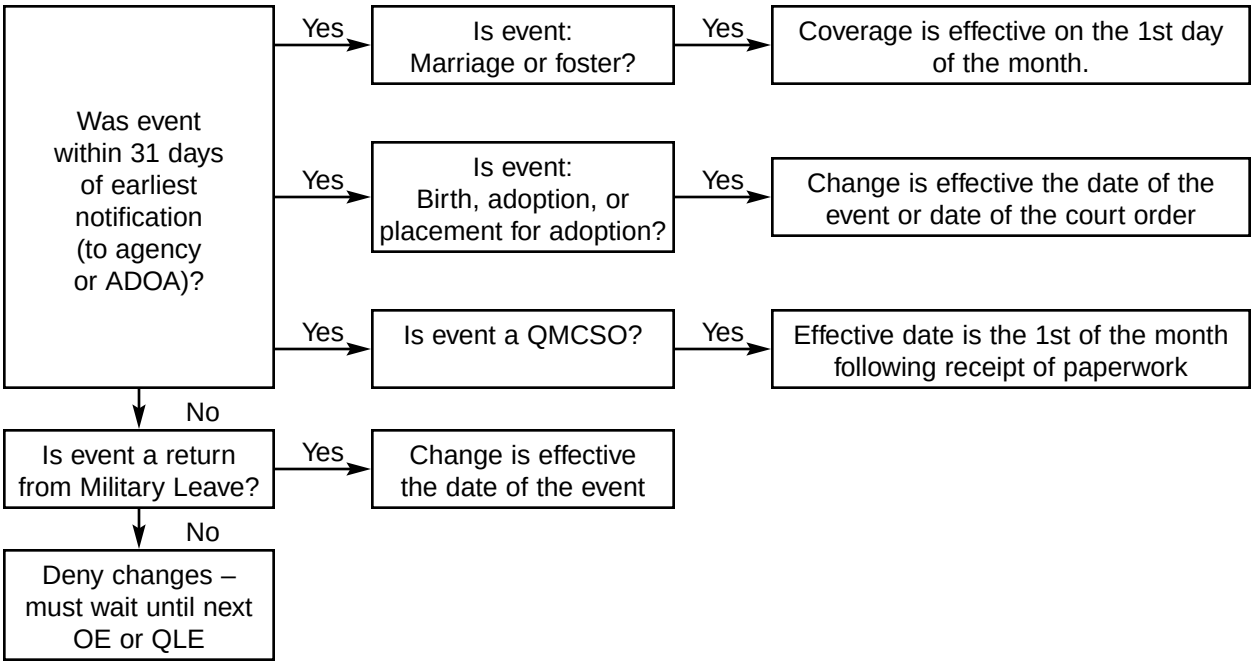
Refer to the following flow charts to determine the effective dates of qualified life events.

Effective Date Flow Charts

Losing Eligibility



Gaining Eligibility



THINGS YOU NEED TO KNOW ABOUT YOUR PENSION CHECK

If you are a new Retiree or make changes to your benefit elections, don't forget to verify your pension check for the correct premium(s) you pay for the plan(s) you elected. If you feel that your pension check is not accurate, you must notify your Retirement System (ASRS or PSPRS) as soon as possible.

If your enrollment is not processed until after the 10th of the month, it is possible that the correct health insurance premium will not be deducted from your pension check until the month following the effective date of your enrollment or change.

If you are an ASRS Retiree, you may believe that the ASRS is charging the full cost of health insurance because your pension check Payment Summary shows the full cost of health care plan premiums under the "Deductions" column.

Please refer to the "Payments" column of your pension check Payment Summary; note the inclusion of additional monies reflected in the PREM BEN (basic premium benefit) and, if applicable, NONSRVPB (non-service area premium benefit or rural subsidy). These two amounts are the premium benefits to which you may be entitled and they offset or reduce the full monthly medical and/or dental premiums you pay.

Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit(s) is applied.

RETIREE HEALTH INSURANCE PREMIUM BENEFIT SUBSIDY PROGRAM

BASIC PREMIUM BENEFIT AMOUNTS

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide a payment toward insurance premiums (i.e., premium benefit), for eligible members and dependents who elect health care coverage through the Arizona Department of Administration (ADOA) or through insurance plans sponsored by the retirement plans themselves.

No premium benefit is provided to Retirees in the University Optional Retirement Plan or to PSPRS or CORP members who are LTD members.

The chart below reflects monthly premium benefits available for eligible members and their qualified dependents.

Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled. To determine your basic premium benefit, you need to know:

- Your years of credited service in your retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).
- Your coverage type (i.e., single or family coverage)
- Whether you and/or your qualified dependents are eligible for Medicare

ADDITIONAL TEMPORARY PREMIUM BENEFIT (RURAL SUBSIDY)

Qualified Medicare eligible retirees who are participating in a medical plan provided by the ADOA and who live in **Mohave, Gila, Navajo or Apache counties** where no managed care (HMO) program is offered (i.e., non-service areas) are entitled to receive an additional temporary premium benefit. The Rural Subsidy amounts are effective from July 1, 2007 through June 30, 2009.

Basic Premium Benefit Amounts

	Without Medicare		With Medicare A & B		Combinations	
Years of Services	**Retiree Only**	**Retiree & Dependents (R&D)**	**Retiree Only**	**Retiree & Dependents (R&D)**	**Retiree & Dependents; one with Medicare, other(s) without Medicare**	**Retiree & Dependent with Medicare, other dependent(s) without Medicare**
Arizona State Retirement System (ASRS) Members						
5.0-5.9	$75.00	$130.00	$50.00	$85.00	$107.50	$107.50
6.0-6.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
7.0-7.9	$105.00	$182.00	$70.00	$119.00	$150.50	$150.50
8.0-8.9	$120.00	$208.00	$80.00	$136.00	$172.00	$172.00
9.0-9.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
10.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0-5.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
6.0-6.9	$105.00	$182.00	$70.00	$119.00	$150.50	$150.50
7.0-7.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
8.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Corrections Officer Retirement Plan (CORP) Members						
No restrictions on years of service	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Public Safety Retirement System (PSPRS) Members						
No restrictions on years of service	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00

Additional Temporary Premium Benefit Amounts (Rural Subsidy)

Monthly Rural Subsidy effective July 1, 2007 through June 30, 2009

	WITH MEDICARE A & B		COMBINATIONS
Years of Services	**Retiree Only**	**Retiree & Dependents**	**Retiree with Medicare, Dependent(s) with or without Medicare**
Arizona State Retirement System (ASRS) Members			
5.0-5.9	$85.00	$175.00	$235.00
6.0-6.9	$102.00	$210.00	$282.00
7.0-7.9	$119.00	$245.00	$329.00
8.0-8.9	$136.00	$280.00	$376.00
9.0-9.9	$153.00	$315.00	$423.00
10.0+	$170.00	$350.00	$470.00
Elected Officials' Retirement Plan (EORP) Members			
5.0-5.9	$102.00	$210.00	$282.00
6.0-6.9	$127.50	$262.50	$352.50
7.0-7.9	$153.00	$315.00	$423.00
8.0 +	$170.00	$350.00	$470.00
Corrections Officer Retirement Plan (CORP) Members			
No restrictions on years of service	$170.00	$350.00	$470.00
Public Safety Personnel Retirement System (PSPRS) Members			
No restrictions on years of service	$170.00	$350.00	$470.00

HB 2311 REQUIRED PAYMENT

Eligible "rural" retirees are required to pay a portion of the cost of their medical insurance plan before the Rural Subsidy is applied to their remaining medical insurance plan. Those amounts are:

Medicare Eligible Retiree Only Required Payment = $100 per month
Medicare Eligible Retiree+ Dependent(s) Required Payment = $200 per month
Medicare Eligible Retiree+ Dependent(s) (Combination Plan) Required Payment = $400 per month

You are responsible to pay all premiums; failure to keep your premiums current will result in cancellation of your insurance coverage. If your premium benefit is equal to or more than your total monthly premium(s), you pay nothing.

- If you are an LTD member or Surviving Spouse not receiving a pension check from a recognized state retirement plan, you are a Direct Pay Member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form.
- If your monthly pension check has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a Direct Pay Member. The Benefit Services Division will notify your current health plan that you did not make a premium payment for that month and will mail a bill to you. It will be your responsibility to pay any outstanding premiums to the Benefit Services Division. If you do not receive a bill by the first of the month, you must contact the Benefit Services Division.
- Should the retirement system begin deducting your premium from your pension check and you have also received a bill as a Direct Pay Member, please contact the Benefit Services Division. Please see the section entitled, "Information for Direct Pay Members."
- Depending on when the Retirement System receives your benefit elections, you may owe one or several months of health and dental premiums. After enrolling, check your pension check deductions. If, by your second pension check the deduction has not occurred or the deduction is incorrect, immediately contact the ADOA Benefit Services Division Office at 602-542-5008.

INFORMATION FOR DIRECT PAY MEMBERS

If you are or become a Direct Pay Member, you will soon receive a billing notice regarding future premium payments. If you do not receive a billing notice within 30 days, please call the following:

For members enrolled in the Arizona Foundation, Beech Street network, RAN+AMN network, or Schaller Anderson Healthcare, please call Fiserv Benefits at 1.800.222.2733 extension 8625.

- For members enrolled in UnitedHealthcare, please call 1.866.747.0047.
- For members enrolled in SecureHorizons, please call 1.800.347.8600.

INFORMATION FOR LONG TERM DISABILITY MEMBERS

Monthly Premiums for Long Term Disability Members can be found on the enrollment form.

I am receiving LTD benefits through a recognized State retirement plan. Am I still considered an active employee of the state?

For purposes of health, dental, and vision benefits, LTD members are considered “Retirees” and will fall under all premiums, processes and guidelines as retired members.

What happens if I am no longer eligible for LTD benefits and not able to retire?

Your eligibility in the Benefit Options plan terminates the end of the month in which you lose eligibility. You may wish to contact your retirement system to determine if you are eligible to enroll in their health plan. It is your responsibility to notify us when your LTD entitlement ends.

What happens if I return to work for the State of Arizona after my LTD ends?

Your return to work will be considered a Qualified Life Event. You must make your new benefit elections within 31 days of your return to work. Please contact your agency Human Resources personnel for further instructions immediately after you lose your LTD eligibility status.

I am receiving LTD and have requested a Waiver of Premium. Does this waive ALL of my insurance premiums?

A Waiver of Premium only applies to life insurance and does not apply to your health, dental and vision benefits. Even if your life insurance premiums are waived, you are still responsible for payment of your medical, dental, and vision monthly premiums.

Your Waiver of Premium eligibility is determined by the LTD carrier. Please contact your LTD carrier with any questions and to learn if you are eligible for a Waiver.

I am receiving disability benefits from Social Security. When will I be eligible for Medicare?

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare. Your Medicare card will be mailed to you about 3 months before your Medicare entitlement date. You must mail a copy of your Medicare card to the Benefits Office within 31 days of receiving the card.

If you are under age 65 and have Lou Gehrig’s disease (ALS), you will be entitled to Medicare the first month you receive disability benefits from Social Security or the Railroad Retirement Board.

For more information, call the Social Security Administration at 1.800.772.1213.

If I am receiving Social Security disability, must I enroll in Medicare Part B coverage?
The Benefit Options health plans require all Medicare-eligible members to enroll in both Part A (hospital insurance) and Part B (medical insurance).

For more information, contact the Social Security Administration or the ADOA Benefits Office.

IMPORTANT INFORMATION FOR NON-MEDICARE ELIGIBLE MEMBERS

If I have retired and return to work for the State/University, will I be able to enroll for benefits as an active employee?
If you return to work for more than 20 hours per week and fall within the Eligibility Rules for active employees, you will be able to enroll in benefits as an employee.

When can I receive Social Security Retirement benefits and Medicare?
If you were born before 1938, your full retirement age is 65. Because of longer life expectancies, the full retirement age is increasing for people born after 1938. You can start your Social Security benefits as early as age 62, but the amount you receive each month will be less than if you start at full retirement age.

Approximately 3 months before your 65th birthday, you will receive your Medicare card. Your Medicare benefits will start the first day of the month you turn 65. You will automatically be enrolled in Part A (hospital insurance) and Part B (medical insurance).

For more information, log on to *www.socialsecurity.gov* or call 1.800.722.1213.

IMPORTANT INFORMATION FOR MEDICARE-ELIGIBLE MEMBERS
Medicare-eligible members may enroll in:

- RAN+AMN EPO plan, Schaller Anderson Healthcare EPO plan statewide.
- Arizona Foundation PPO plan in all counties.
- UnitedHealthcare EPO or PPO plans in Maricopa, Pima, Pinal, and Santa Cruz counties.
- SecureHorizons MedicareComplete HMO plan in Cochise, Coconino, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. SecureHorizons requires that the retired member must be enrolled in Medicare Parts A & B to enroll.

MEDICARE PART A & PART B INFORMATION

Who is eligible for Medicare Part A and Part B coverage?
Generally, Medicare is available to people:

- age 65 or over
- under age 65 with disabilities receiving LTD from a State-sponsored LTD plan or SSI.
- with End Stage Renal Disease.

Eligibility is determined by the Social Security Administration.

Who pays for Medicare Part A and Part B coverage?

- Most people do not have to pay for Part A.
- You pay for Part B if you are eligible and do not decline the coverage. *However, you will be financially liable for medical costs incurred if you DO NOT take Part B. These costs will not be paid for by your ADOA Benefit Options health plan.*

I (or my spouse or my dependent) have Medicare Part A and Part B, and I have the Benefit Options Retiree or LTD coverage. Who pays first?
If you are retired and receiving a pension check from a recognized State Retirement Plan, **OR** you are receiving LTD benefits from a State recognized disability plan (*VPA, Standard Insurance, CIGNA, or Fortis, not Social Security disability benefits*):

- Medicare is primary coverage.
- Benefit Options is secondary coverage.

Am I eligible for the SecureHorizons MedicareComplete Plan?
You are eligible for the MedicareComplete Plan if:

- At least one member of your household enrolling is Medicare eligible
- You are the primary Retiree
- You live in Coconino, Cochise, Graham, Greenlee, La Paz, Maricopa, Pinal, Pima, Santa Cruz, Yavapai, or Yuma counties.
- You or your dependent(s) have Medicare Part A and Part B coverage.

Please note: Your non-Medicare eligible Spouse or Dependent will have coverage under the UnitedHealthcare EPO plan.

What happens if I do not elect Medicare Part B coverage with Social Security?
You will need to contact the Social Security Administration to learn how this will affect your coverage. You will be financially liable for medical costs incurred if you DO NOT take Part B. These costs will not be paid by your ADOA Benefit Options Health plans.

I am eligible for Medicare Part B coverage; however, I have not elected Medicare Part B coverage. How are my medical benefits coordinated?
You will assume the same financial responsibility for the medical benefits Medicare B would

have covered if Medicare Part B coverage was in effect. You must, therefore, pay the medical bills that Medicare B would have paid. *These costs will not be paid for by your ADOA Benefit Options health plan*.

What Benefit Options plan do I elect?
You may elect the EPO or PPO plan listed under "with Medicare" available in your county for retiree and long-term disability members.

Your Benefit Options plan remains the secondary payer for all covered services.

If I purchase both Part A and Part B of Medicare, why should I continue to be enrolled in the Benefit Options program?
This is a decision that must be made by the member. Medicare only pays 80% of covered charges once you have met your deductible. Physicians often charge patients the remaining portion of the bill that Medicare has not paid.

The Benefit Options plan also incorporates Walgreens Health Initiatives (WHI) for pharmacy coverage. There are no annual limits or caps on preferred or non-preferred medications. Copays are $10, $20, or $40.

To be eligible for the SecureHorizons plan, all Medicare eligible members must have Medicare Parts A & B.

If I am receiving Medicare, why do I still pay copays?
A copay is the portion paid by the member to share in the cost of medical services, supplies and prescriptions. This cost sharing will help the Benefit Options program with rising healthcare costs.

Medicare also applies cost sharing. For covered services, the Benefit Options self-funded plans (excluding SecureHorizons plan) absorb the Medicare deductible you would otherwise pay for hospital and medical services. The Benefit Options program will pay up to the total allowable amount as determined by the Plan. Most physicians generally charge 20% above the amount covered by Medicare.

Copays are required for all plan members including retirees, non-Medicare eligible Retirees, LTD members, Surviving Spouse and Medicare eligible Retirees. Your medical provider understands medical payments will be reduced by the copayment. Therefore, it must be submitted at the time the services are rendered.

I am not enrolled with SecureHorizons. I do not want to be responsible for filing claims with the health plan after my physician has filed with Medicare. What should I do?
Both Fiserv Benefits and UnitedHealthcare have a Medicare Crossover program. Please call the number on the back of your card and let them know you would like to enroll in the Medicare Crossover program.

For more information, please see the Coordination of Benefits With Medicare section.

Who is responsible for notifying ADOA of a Medicare change?
If you become eligible to receive Medicare due to a disability, receive your Medicare card prior to your 65th birthday, or there is a change in your Medicare status, you must contact the ADOA Benefits Office with this information. If you receive your new Medicare card, you must provide a copy of it to the Benefits Office. Medicare does not communicate directly with ADOA.

SecureHorizons MedicareComplete

What is the SecureHorizons MedicareComplete HMO Plan?
SecureHorizons is a MedicareComplete HMO plan for members who are enrolled in Medicare Parts A and B and in which SecureHorizons has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare and is regulated by the Arizona Department of Insurance.

This contract authorizes SecureHorizons to provide comprehensive health services to persons who are entitled to traditional Medicare benefits and who choose to enroll in the MedicareComplete HMO Plan (SecureHorizons). By enrolling in the MedicareComplete HMO Plan (SecureHorizons) you have made a decision to receive all of your routine health care from SecureHorizons contracted providers. If you receive services from a non-contracted provider without prior authorization, except for emergency services or critical out-of-area services such as renal dialysis, neither SecureHorizons nor Medicare will pay for those services.

If you elect the MedicareComplete HMO plan, you must choose a Primary Care Physician.

Statement of Understanding (SOU)
Any Retirees, LTD members, Surviving Spouse, and/or dependents who have Medicare Parts A and B and who are enrolling in the SecureHorizons MedicareComplete HMO Plan must complete the Statement of Understanding. The completed SOU must be submitted to the ADOA Benefits Office prior to the first day of the month in which coverage becomes effective. The form may only be submitted between Monday and Friday. Your signature on the SOU form confirms to SecureHorizons and CMS that you, your spouse and dependent(s) understand:

- Member(s) must maintain Medicare Parts A and B by continuing to pay the Part B premiums, and if applicable, the Part A premiums.
- All medical services, with the exception of emergency or out-of-area urgently needed services must be provided by or arranged by SecureHorizons contracted providers.
- Services rendered without precertification from SecureHorizons, with the exception of emergency and out-of-area urgently needed services, will not be reimbursed by SecureHorizons or Medicare.
- The member(s) is bound by the benefits, copayments, exclusions, limitations and other terms of the SecureHorizons Evidence of Coverage.
- The member(s) may only be enrolled in one MedicareComplete HMO Plan at any one time.

- The effective date of the MedicareComplete HMO Plan (SecureHorizons) selection will be the first of the month following the date that SecureHorizons receives the completed enrollment form and SOU, unless the requested effective date is at a later date.
- If you are currently enrolled in the SecureHorizons plan and wish to change to one of the other plans offered during Open Enrollment, it will be necessary for you to submit a written statement of voluntary disenrollment.

How is the SecureHorizons MedicareComplete program different from the ADOA Benefit Options program?
The SecureHorizons program is federally approved by Medicare and operates an HMO plan on behalf of Medicare. This is a fully-insured plan designed by SecureHorizons. What the plan covers, copayments, and how the plan operates is contracted and agreed upon between SecureHorizons and Medicare. This is a more managed plan with some restrictions; however, monthly premiums are lower than the other plans offered by Benefit Options. You will need to select a Primary Care Physician and network when you enroll with SecureHorizons.

The other plans offered in the Benefit Options program are self-funded plans and are controlled by ADOA. Although these plans coordinate benefits with Medicare, they are not mandated by Medicare on how the plans operate or what they will cover. These plans offer the same comprehensive benefits as those received by State employees. This is a less-managed plan with more flexibility; however, premiums are higher. You do not need to select a Primary Care Physician and may self-refer to see a specialist. All providers must be contracted within the network you select.

COORDINATION OF BENEFITS WITH MEDICARE
Medicare is the primary coverage. After Medicare pays, the Arizona Benefit Options plan will pay as the secondary payer for covered benefits in accordance with the Plan provisions. The Plan Administrators (Fiserv Benefits and UnitedHealthcare) will coordinate medical claims with Medicare.

Members enrolled with SecureHorizons do not need to worry about coordination of benefits, since SecureHorizons will operate as the primary plan on behalf of Medicare.

All Medicare-eligible plan members will pay the appropriate copays for provider services, emergency and urgent care services or coinsurance.

Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson Healthcare Members:
Fiserv Benefits, the Plan Administrator, will provide “cross-over” services. If your provider accepts Medicare assignment, they may submit a medical bill directly to Medicare. Fiserv Benefits will receive an electronic copy of the reduced bill, your Explanation of Medicare Benefits (EOMB) statement, directly from Medicare. This eliminates the need for you or your provider to send a second bill to Fiserv for the portion of the costs Medicare did not pay. You must complete an enrollment form to begin these services.

To request a Medicare Crossover form, contact Fiserv Benefits at 1.888.999.1459.

UnitedHealthcare Members:
When Medicare receives a provider bill and pays their portion, the Explanation of Medicare Benefits (EOMB) is sent directly to the provider. Your provider will send any unpaid portions to UnitedHealthcare. You will not need to send a second bill to UnitedHealthcare for payment.

If you have any questions, contact UnitedHealthcare at 1.800.896.1067.

INFORMATION ON MEDICARE PART D

The Medicare Modernization Act (MMA) was signed into law by President Bush in December 2003. A key aspect of this Act is the new prescription drug benefit, known as Medicare Part D. Medicare Part D took effect on January 1, 2006. This benefit is offered to all Medicare-eligible Retirees or LTD members enrolled in Medicare Part A, Medicare Part B, or both Parts A and B.

- You will not be automatically enrolled in Medicare Part D.
- You are not required to enroll in Medicare Part D.

The Arizona Benefit Option Plans have filed with Medicare to offer "creditable coverage" for pharmacy coverage. This means the ADOA health plan has equal to or better pharmacy coverage than will be provided through Medicare.

Low Income Assistance

If you have limited income and resources, you may qualify for extra assistance through Medicare. Most people who qualify for this extra help will pay no premiums, no deductibles, and will not pay copays over $5.00 for each prescription. You may qualify if your income is less than $14,355 or $19,245 for a married couple and your resources are less than $11,500 if you are single or $23,000 if you are married and living with your spouse. You automatically qualify for prescription assistance if you:

- have Medicare and full coverage from a state Medicaid program that currently pays for your prescriptions.
- get help from your state Medicaid program paying your Medicare premiums (or belong to a Medicare Savings Program).
- get Supplemental Security Income.

If you would like more information or to see if you qualify for assistance, call 1.800.722.1213, log on to *www.socialsecurity.gov*, or visit your local Social Security Office.

If you qualify for assistance, you will need to disenroll from the ADOA Benefit Options program (including SecureHorizons). When you receive your confirmation of acceptance, please contact the ADOA Benefits Office for more information.

Do I Need to Enroll in a Pharmacy Plan Outside of the ADOA Plans?

No, you do not need to enroll in a Medicare Part D Prescription Drug Plan. Although every Medicare eligible person has the protected right to enroll in a separate Pharmacy Benefit Plan (PDP) if he or she wishes to do so, the ADOA health plans have filed with Medicare to provide this coverage to you. The ADOA Benefit Options program provides equal to or better coverage than what is offered through Medicare Part D:

- You will not have to pay a separate monthly premium for Medicare Part D;
- You will not have to pay an annual deductible;
- You will not need to pay a percentage of your prescription costs; and

- Your medications will remain at the current $10, $20, and $40 copay levels.

What Happens If I Enroll in a Separate Pharmacy Plan?
If you enroll in a separate Prescription Drug Plan, you cannot remain enrolled in the ADOA health plan. Medicare does not allow a Medicare-eligible person to be enrolled in two approved Medicare prescription drug plans at the same time. However, you will need to decide what is right for you and your family. For some members, enrolling in a separate Prescription Drug Plan (PDP) and disenrolling from the Benefit Options program may be cost-effective and the right choice for them.

If you would like more information, log onto *www.medicare.gov* or call 1.800.633.4227.

ARIZONA, NATIONAL AND INTERNATIONAL COVERAGE

(Medical, Dental, and Vision)

	Within Arizona	Within U.S.	International
MEDICAL			
EPO Plans			
RAN+AMN	Covered in-network	Covered using Beech Street Provider	Emergency and Urgent Only
Schaller Anderson Healthcare	Covered in-network	Covered using Beech Street Provider	Emergency and Urgent Only
UnitedHealthcare	Covered in-network	Covered using UHC EPO provider network	Emergency and Urgent Only
PPO Plans			
Arizona Foundation	Covered in/out-network	Covered using AZF PPO in/out-network or Beech Street Provider	Covered out-of-network
Beech Street	Covered in/out-network	Covered in/out-network	Covered out-of-network
UnitedHealthcare	Covered in/out-network	Covered using the UHC PPO in/out provider network	Covered out-of-network
NAU Only			
BlueCrossBlueShield PPO		Outside AZ: Covered as in-network *only* if you receive covered services from a provider who participates as a PPO provider with the local BCBS plan. For assistance in locating a local BCBS network provider in another state, call 1.800.810.2583.	For assistance with locating a provider and submitting claims, call 1.800.810.2583 or 1.804.673.1686. For an international claim form, go to www.bcbs.com/bluecardworldwide/index.html
PHARMACY			
Walgreens Health Initiatives	Covered in-network	Covered in-network	Not Covered
DENTAL			
Prepaid Plans			
Assurant Employee Benefits	Covered in-network	Emergency Only	Emergency Only
EDS	Covered in-network	Emergency Only	Emergency Only
PPO Plans			
Delta Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
MetLife Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
VISION			
Avesis	Covered in-network	Covered out-of-network	Covered out-of-network

Note: Treatment will be subject to the Plan Description.

MEDICAL PLAN FEATURES

What is a Plan Administrator?
A Plan Administrator is the contracted organization that processes the medical claims, provides customer service and runs the day-to-day operations of the health plan:

- If you are enrolled with the Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson networks, your plan administrator is Fiserv Health - Harrington Benefit Services.
- If you are enrolled with UnitedHealthcare, your plan administrator is UnitedHealthcare.
- The ADOA Benefits Office is the Plan Sponsor - not the Plan Administrator.

I've heard the terms, "integrated" and "non-integrated." What do they mean?
Integrated and non-integrated describe the way services are provided in each health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson, you are in the non-integrated plan. This means multiple organizations supply the health plan services:
  - Arizona Foundation, Beech Street, RAN+AMN and Schaller Anderson provide the network of hospitals and medical providers.
  - Fiserv Health - Harrington Benefit Services provides the claims payment processes, day-to-day operations, customer service.
  - Schaller Anderson provides the prior authorization, disease management, and medical review services.
- If you are enrolled with UnitedHealthcare, the integrated plan, UnitedHealthcare provides the following: hospital and provider networks; payment processes and day-to-day operations; and prior authorization and disease management services.
- Walgreens Health Initiatives (WHI) is a Pharmacy Benefit Manager and provides pharmacy services for both the integrated and non-integrated health plans.

What is a Pharmacy Benefit Manager?
A Pharmacy Benefit Manager provides the national network of pharmacies, mail-order service, and specialty pharmacy services. A Pharmacy Benefit Manager manages pharmacy benefits in the following ways: by providing discounts on medications through the use of a formulary; by reviewing the way medications are used by members; and by implementing targeted programs to reduce overall pharmacy costs. These programs promote the use of cost-effective medications, maximize generic efficiency, and encourage proper utilization. A Pharmacy Benefit Manager also works with physicians to review medications prescribed and looks for possible lower cost alternatives.

What is an "EPO" plan and how is this different from a "PPO" plan?
An EPO (Exclusive Provider Organization) is a managed care plan which means you must use providers who are contracted with that health plan. You must pay any copays as indicated. If you are enrolled in an EPO and use a provider who is not contracted with the plan, you will be

personally liable for their bill. A PPO plan is a Preferred Provider Organization and allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a deductible and will pay a percentage of all covered services.

The State offers "open access" in all of the EPO plans. What does this mean?
Open access refers to how you "access" physicians. Instead of getting a referral from your Primary Care Physician (PCP) to see a specialist, you may schedule an appointment directly with a specialist of your choosing. The specialist MUST be contracted within your network. However, if you wish to obtain specialist referrals through your PCP, you may do so.

If my PCP refers me to a specialist or medical provider that is NOT within my EPO network, am I responsible for the medical charges?
Yes. In the EPO plan, all medical services received must be contracted network medical providers.

If your PCP has scheduled an appointment for x-rays, laboratory tests, or specialists, you must make sure they are within your medical network.

If you are enrolled in the PPO plan, you may obtain out-of-network services and pay 30 percent of the covered charges, after you have met your deductible.

How do I find out what is covered in the health plan?
Covered benefits are described in a book called a Plan Description. A plan description outlines your health insurance coverage and provides information on how claims will be paid, services that require pre-certification, services that are covered and items that are excluded by the health plan. You will receive a copy of the plan description after the beginning of a new plan year. You may also view these descriptions online at *www.benefitoptions.az.gov*.

I have been contacted by someone and asked if I want to participate in a disease management program. What is disease management?
Disease Management is a voluntary service provided through an organization contracted with the State of Arizona, that assists members with treatment needs for chronic conditions. If you are being treated for any of the conditions listed below, you will be contacted by the Disease Management staff with further information on the program. This is a free service to provide you information, assistance, and resources to manage the following conditions:

- Asthma
- Congestive Heart Failure
- Diabetes
- Coronary Artery Disease

What is a network service area?
A network service area is the region in which your network is offered:

- The Arizona Foundation PPO plan is offered statewide.

- The Beech Street PPO plan is offered for members living outside of Arizona and will be used as a national travel network if you are enrolled with Arizona Foundation, RAN+AMN, or Schaller Anderson.
- The RAN+AMN EPO plan is offered statewide.
- The Schaller Anderson EPO plan is offered statewide.
- The UnitedHealthcare EPO and PPO plans are offered in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties.
- SecureHorizons is offered in Coconino, Cochise, Graham, Greenlee, LaPaz, Maricopa, Pinal, Pima, Santa Cruz, Yavapai, and Yuma Counties.

What is Coordination of Benefits?
When a retiree has more than one health plan or is considered a covered dependent under another plan, benefits are coordinated so that no more than 100 percent of the claim is paid to a medical provider. One plan will be considered primary and the other will be considered secondary. For additional information on how coordination of benefits will be applied, please refer to the appropriate plan description.

What is Transition of Care?
If you are a new retiree and/or changing from Arizona Foundation, Beech Street, RAN/AMN, or Schaller Anderson to UnitedHealthcare (or from UnitedHealthcare) to other state offered coverage you may continue an active course of treatment with your health care provider and receive in-network benefits during the pre-approved transition period, if one of the following applies:

1. You have a life threatening disease or condition;
2. If you have been receiving care, and a continued course of covered treatment is Medically Necessary, you may be eligible to receive “transitional care” from the non-Participating Provider;
3. You have entered the third trimester of pregnancy on the effective date of enrollment; or
4. If you are in your second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan’s policies and procedures and quality assurance requirements.

There may additional circumstances where continued care by a provider no longer participating in the network will not be available, such as when the provider loses his license to practice or retires. You may obtain a copy of the Transition of Care form at *www.benefitoptions.gov*.

I’m enrolled in the NAU BCBS plan. How can I get information about that plan?
This plan is available only to NAU retirees. For information, visit *http://hr.nau.edu/m/* and choose Benefits, Health, BCBS Plan Book.

MEDICAL PLANS COMPARISON CHART

	EPOs	PPOs		SecureHorizons	
				High Option	Low Option
These plans are available to retirees statewide	RAN+AMN EPO Schaller Anderson Healthcare EPO	Arizona Foundation PPO Beech Street (Out-of-State only)		SecureHorizons is offered in Cochise, Coconino, Graham, Greenlee, La Paz, Maricopa, Pinal, Pima, Santa Cruz, Yavapai and Yuma counties	
In addition to the plans above, the following plans are offered to retirees in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties	UnitedHealthcare EPO	UnitedHealthcare PPO			
DEDUCTIBLE/MAXIMUMS	**In-Network (Copayments)**	**In-Network (Copayments)**	**Out-of-Network (Out-of-Pocket)**	**In-Network (Copayments)**	**In-Network (Copayments)**
PCP REQUIRED FOR EACH MEMBER?	No	No	No	Yes	Yes
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	No	No	No	Yes	Yes
PLAN YEAR DEDUCTIBLES INDIVIDUAL RETIREE + ONE / FAMILY	None None	None None	$300 $600	None None	None None
OUT-OF-POCKET MAXIMUMS INDIVIDUAL RETIREE + ONE / FAMILY	None None	$1,000 $2,000	$3,000 $6,000	None None	$2,400 per person
LIFETIME MAXIMUMS	None	N/A	$2,000,000	None	None
PHYSICIAN SERVICES Office Visits/consultations	$10 copay, Max of 1 copay/day/provider	$10 copay, Max of 1 copay/day/provider	30%	PCP - $10 copay	PCP - $10 copay
SPECIALIST VISITS (new copay)	*$20*	*$20*	*30%**	Specialist - $10 copay	Specialist - $20 copay
MAMMOGRAPHY SCREENING (Coverage based on patient age or threat)	None	None	30%	None	$10 copay
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	None	None	30%	None	$125 copay
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	None	None	30%	None	$500 copay
Intensive Care	None	None	30%	None	$500 copay
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologist	None	None	30%	None	None
EMERGENCY CARE Urgent Center Care	$20 copay	$20 copay	30%	$20 copay	$35 copay
Emergency room (new copay)	*$125, waived if admitted*	*$125, waived if admitted*	*$125, waived if admitted*	*$50 copay*	*$50 copay*
Ambulance (for medical emergency or required interfacility transport)	$0	$0	Emergency paid at in network benefit rate	None	$100
CHIROPRACTIC	$10	$10	30%* After Deductible	$10 copay; Medicare covered services	$20 copay; Medicare covered services
PRE-EXISTING CONDITIONS	Covered	Covered	Covered	Covered	Covered
DURABLE MEDICAL EQUIPMENT	$0	$0	30%* After Deductible	$0	20% coinsurance
BEHAVIORAL HEALTH					
Outpatient	$10	$10	$10	$10 copay	$10 - Group Visit $20 - Individual Visit
Inpatient	$0	$0	30%* After Deductible	$0; limit of 190 days lifetime	$500 copay; limit of 190 days lifetime

**Percentages paid based on Reasonable and Customary Charges.*

This is a Summary only; please see Plan Descriptions for detailed provisions.

For the NAU only BCBS PPO plan details, go to http://hr.nau.edu/m/ *and choose Benefits, Health, BCBS Plan Book.*

ONLINE FEATURES OF MEDICAL PLAN INFORMATION

Members can now review their personal profile, view the status of medical claims, obtain general medical/pharmacy information, and learn how to manage their own healthcare through the available health plan websites.

Arizona Foundation, Beech Street, RAN+AMN, or Schaller Anderson
Members enrolled with any of the providers above may view the following information on *www.myazhealth.com* (you will need to register with a user name and password):

Personal Profile	Check your eligibility status and personal profile.
Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or copays made; the amount paid to the provider; and details on provider payments.
Deductible Status	View all of the copays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
Secure Mail	With the "Secure Mail" feature, you may ask questions anytime day or night. You will receive replies about your confidential health benefit information within 3 business days without the worry of transmitting your personal information over the internet.
Health Information	Compare hospitals based on quality of care, procedures and patient safety measures. You may also view a medical encyclopedia, information on general health topics, and an outline of questions you should ask your doctor.
Medline Plus	Medline provides extensive health information on over 650 diseases and conditions; provides a medical dictionary and encyclopedia; information on clinical health trials; and the latest medical research in medicine.
Provider Search	You may click on your network to research contracted network physicians, hospitals, and medical providers.
Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
Claim Forms	You may download claim forms and information to submit claims for medical services and reimbursement for out-of-pocket expenses.

UnitedHealthcare

Members enrolled in UnitedHealthcare can view the following information on *www.myuhc.com* (you will need to register with a user name and password):

Personal Profile	Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.
Provider Search	Find the physicians and hospitals that are convenient and right for you.
Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or copays made; the amount paid to the provider; and details on provider payments.
Deductible Status	View all of the copays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
Hospital Comparison	Compare hospitals based on quality of care, procedures, and patient safety measures with the Hospital Comparison tool.
Treatment Cost	Find out and compare what different treatments will cost using the Treatment Cost Estimator before you need to make a decision.
Health Information	Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and BestTreatments organizations.
Nurseline	Chat online with Registered Nurses 7 days a week for trusted information and peace of mind when you have a question or during times when you cannot get to your doctor.
Expert Information	Participate in monthly online events with leading experts in health care.

SecureHorizons

SecureHorizons members can view the following information on *www.pacificare.com*:

Provider Search	Find the physicians and hospitals that are convenient and right for you
24 Hour Health Info	Part of SecureHorizons' 24-Hour Health Information program, this area offers valuable information about medical conditions, health, and lifestyle management, plus tools, diaries, calendars and even a personal health record.
Take Charge Programs	Tools and information to help you take charge of diabetes, depression, heart conditions, anti-smoking assistance, and valuable tips to get the most out of your next doctor's visit.
Pharmacy Information	Information on the RX Solutions pharmacy program, mail order service, formulary information and generic drug information.
Resource Center	Valuable information for caregivers; informative articles on health related topics and how to get the most out of your health care; and internet links to a variety of health related organizations.

How To Use Your Pharmacy Plan

How does the plan work?
The WHI network consists of more than **62,000** participating chain and independent pharmacies nationwide, with **1,000** member pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work address, out-of-town vacation address, or your dependent student's out-of-state address, refer to *www.mywhi.com*.

Multilingual customer service representatives are available 24 hours a day, 7 days a week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary; the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for a generic drug, $20 for a preferred (formulary) drug, and $40 for a non-preferred (non-formulary) drug. You can find information on WHI's formulary and look up the cost for specific drugs at *www.mywhi.com*.

Generic and brand name medications
If a name brand medication is prescribed by a physician as "substitution permissible" and a generic version of the medication is available, members who elect to purchase the brand name medication will pay the difference between the actual cost of the brand-name medication and the actual cost of the generic version.

If a name-brand medication is prescribed by the physician as "Dispense as Written" or "No Substitutions", the member would be charged the standard copay rate for the name brand.

For example: The cost of a brand name medication is $100 with a $40 copay and the cost of the generic version is $30 with a $10 copay. When prescribing the medicine, if the physician indicates that either the brand or generic version is acceptable, the cost will be $70 ($100 - $30) if the member elects to purchase the brand name or $10.00 if the member elects the generic brand. If the physician specifically prescribes the brand name to the member and does not allow for any substitution of a generic version, the member will pay the copay of $40.00 for the brand name prescription.

Generic drugs help you save money without compromising quality. The United States Food and Drug Administration (FDA) require generics to be as safe and effective as their brand-name counterparts. Nearly 50% of all prescriptions in the U.S. are now filled with generic medications. Your doctor may choose to prescribe a generic for you, or, if he or she recommends a brand name, you can ask if a generic is available. Pharmacists will usually substitute a generic for a brand name, unless otherwise directed by your doctor or prohibited by law. You will pay the lowest copay for generic drugs. Generic prices on average are 20 to 50 percent lower than their brand-name counterparts, so your choice of generics can help keep the Plan's costs down and benefits high.

Health Management Programs
Before attempting to have a new prescription filled, it is recommended that you check WHI's online formulary to see if the medication might be categorized under one of the following Health Management Programs:

Clinical Prior Authorization
Prescriptions for certain medications or circumstances require pre-authorization before they can be filled, even though you have a valid, current prescription. Prescriptions may be limited to an amount, quantity, frequency, or may have age restrictions. The Clinical Prior Authorization can be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Specialty Pharmacy Program
Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Health Initiatives (WHI) Specialty Pharmacy. This program assists you with monitoring your medication needs for conditions such as those listed below and providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods and special storage, handling and delivery.

Medications for these conditions through the Specialty Pharmacy Program include, but are not limited to:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service. Call WHI at 1.888.782.8443 for further information on this program.

A Specialty Care Representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff is available 24 hours a day, 7 days a week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

SECUREHORIZONS MEMBERS
If you elect the SecureHorizons plan, Prescription Solutions will provide your pharmacy benefits. Prescriptions Solutions, a wholly-owned subsidiary of SecureHorizons, offers benefits at a network of local pharmacies.

How to Use the Prescription Solutions Program
Present your SecureHorizons membership card at any SecureHorizons contracting pharmacy. Pay your copay for each prescription unit of medication or the retail cost of the prescription, whichever is less.

What is the Formulary?
The Formulary is a list of outpatient prescription drugs that are covered by SecureHorizons when prescribed by a SecureHorizons contracting provider and filled at a SecureHorizons contracting pharmacy. The Formulary was created and is regularly updated by a Pharmacy Therapeutics Committee, which consists of practicing physicians and pharmacists. This committee decides which prescription drugs provide quality treatment for the best value. Your physician has a copy of the Formulary and will use it as a reference when prescribing medications. The Formulary is available at *www.pacificare.com*.

What is Covered?
All medications listed in the Formulary are covered when ordered by a SecureHorizons contracting provider and filled at a SecureHorizons contracting pharmacy. The Formulary includes a broad range of FDA-approved generic and some brand name medications that under State or Federal law are to be dispensed by a prescription only.

What is the Mail Order program?
Mail service makes it easier for you to receive the prescriptions you take on a regular basis such as medications for high blood pressure, diabetes, and asthma. Each order is processed separately by a licensed pharmacist supported by a sophisticated computerized quality control system designed to protect you against harmful drug interactions. If there are any questions, your physician will be called.

When you receive your prescription, it will include detailed personalized instructions on how to take the medication, possible side effects and other pertinent information. If you have any questions, registered pharmacists are available to help you.

Prescriptions are mailed via the United States Postal Service directly to your home in a discreetly labeled envelope to ensure privacy and safety. Ask your doctor to prescribe a 90-day supply plus refills and by using the mail service program, you will save both time and money. The copayment for the 90-day supply is equivalent to two month’s copayment.

For more information about the Mail Service Prescription Drug Program, please contact Prescription Solutions Customer Service at toll free 1.877.889.6358, TTY 1.800.498.5428, 24 hours a day, 7 days a week.

Mail Order Service

A convenient and less expensive mail-order service is available for retirees who require maintenance medications for on-going health conditions or who are going to be in an area with no participating retail pharmacy for an extended period of time. Here are some of the guidelines and benefits of using the mail-order services:

- You must submit a written 90-day prescription from your physician for any new mail order drug.
- You may request up to a 90-day supply of medication for two copays.
- You may pay by check or charge your copay to a Visa, MasterCard, American Express or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at *www.mywhi.com* or via phone at 1.866.722.2125.
- One-on-one consultations with a licensed pharmacist are also available at this number.

NAU RETIREE BCBS MEMBERS ONLY

There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, nonpreferred brand A, or nonpreferred brand B copayment.

The BCBSAZ Prescription Medication Guide can be used to determine your copayment and this guide can be found on the BCBS website at *https://www.bcbsaz.com/pharmacy*. Go to 4 level prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copayment for the 90-day supply is equivalent to two month’s copayment. More complete information on your BCBS prescription drug benefit can be found in the benefit plan booklet at *https://hr.nau.edu/m*/. Go to Benefits, Health, BCBS Plan Book.

ONLINE FEATURES OF PHARMACY PLAN INFORMATION

WHI members enrolled in Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson and UnitedHealthcare can view pharmacy information by registering at *www.mywhi.com*:

Copay and Drug Information	You may research your medication to learn what copay is required at retail or through mail-order service.
Eligibility Information	Check your eligibility status for you and your family members.
Search the Formulary	You may research medications to determine whether they are generic, preferred or non-preferred drugs. This classification will determine what copay is required.
Download the Formulary	You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
Locate a Nearby Pharmacy	You may view pharmacies in your area by zip code or city.
Prescription History	You may view your entire prescription history, including all of the medications received by each member.
Mail Service Forms	You may register for mail-order service by downloading the registration form and following the step-by-step instructions.
Refill Information	You may review refill information, including when your next refill can be ordered and available options to request your next refill.
Drug Information	You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
Product News	The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

SecureHorizons Members

SecureHorizons Members can view pharmacy information by registering at *www.rxsolutions.com*.

Copay and Drug Information	You may research your medications to learn what copay is required at retail or through mail order service.
Search the Formulary	You may research medications to determine whether they are generic or preferred drugs. This classification will determine what copay is required.
Download the Formulary	You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
Locate a Nearby Pharmacy	You may view pharmacies in your area by zip code or city.

Refill Information	You may review refill information, including when your next refill can be ordered and available options to request your next refill.
Drug Information	You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
Product News	The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

Blue Cross/Blue Shield Members
Blue Cross/Blue Shield Members (NAU Retirees Only):

Refer to more complete information by accessing Blue Net, BlueCross/BlueShield of Arizona's online member website at the following address: *www.bcbsaz.com*. Information on the pharmacy plan and copayment levels for prescriptions can be found at www.bcbs.com/pharmacy; go to 4-level prescription drug benefit.

PHARMACY PLAN COMPARISON CHART

	ADOA Benefit Options (Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson, UnitedHealthcare)	SecureHorizons High Option	SecureHorizons Low Option	BC/BS NAU Retirees Only
Pharmacy Benefits Administered By	Walgreens Health Initiative	Prescription Solutions	Prescription Solutions	Blue Cross/ Blue Shield
Retail Requirements	In-network pharmacies only: one copay per prescription	In-network only: one copay per prescription	In-network only: one copay per prescription	In-network only: one copay per prescription
Mail Order	Two copays for 90-day supply	Two copays for 90-day supply	Two copays for 90-day supply	One copay for 90-day supply
Generic	$10 copay	$7 copay	$20 copay	$7 copay
Preferred Brand	$20 copay	$20 "brand"	$40 "brand"	$20 "brand"
Non-preferred Brand	$40 copay	Not Covered	Not Covered	$40 for non-preferred brand "A" $80 non-preferred brand "B"
Annual Maximum	None	None	None	None

DENTAL PLANS

How To Use Your Dental Plan
Following is a brief description of the dental plans available through Benefit Options. For a complete listing of covered services for each plan, please refer to the plan description located on the website, www.benefitoptions.az.gov. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your copayment.

Prepaid Plans - EDS and Assurant

- You must see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums.
- No claim forms.
- No waiting periods.
- Pre-existing conditions are covered.
- Set copayments for services provided by your general dentist.

Employers Dental Services (EDS)
You must choose one dentist for your family from a network of participating dentists. You can change your dentist at any time by contacting EDS or by using the “change my dentist” function on the website www.mydentalplan.net. Members can self refer to Specialists within the network. Specialty services are provided at up to a 25% discount off the Specialist’s normal fees. Separate lab fees apply to some services as indicated in the schedule of benefits.

Assurant Employee Benefits
Each family member can choose a different dentist. You can self refer to a Specialty Benefit Amendment (SBA) Specialist in the Network who accepts a copay for most common procedures, listed under the SBA. If a procedure is not listed in the SBA copay schedule or the Specialist does not participate in the SBA, you will receive a discount off the Specialist’s normal retail charges. This discount also includes Orthodontic Services.

Indemnity/PPO Plans - Delta Dental and MetLife Dental

- You may see ANY dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- $1,500 maximun benefit per person per lifetime for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental
Over 80 percent of Arizona’s licensed dentists participate in the Delta Dental Plan and agree to

accept Delta's allowable fee as payment in full after any deductibles and/or copayments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

MetLife Dental
MetLife participating dental providers (PDP) accept negotiated fees as payment in full after your deductibles and copayments are met. These fees are typically 15–30 percent below average rates. Noncovered services provided by a PDP dentist are also charged at a lower rate. Covered expenses from a nonparticipating dentist are paid according to established reasonable and customary charges.

DENTAL PLANS COMPARISON CHART

	Employers Dental Services	Assurant Employee Benefits	Delta Dental	MetLife Dental
PLAN TYPE	Prepaid	Prepaid	Indemnity/PPO	Indemnity/PPO
DEDUCTIBLES	None	None	$50/$150	$50/$150
PREVENTIVE CARE	Co-Pay	Co-Pay	Co-Insurance	Co-Insurance
Office Visit	$5	*$10*	$0 Deductible Waived*	$0 Deductible Waived*
Oral Exam	$0	$0	$0 Deductible Waived	$0 Deductible Waived
Prophylaxis/Cleaning	*$7*	*$5*	$0 Deductible Waived	$0 Deductible Waived
Fluoride Treatment (to age 19)	$0	$0	$0 Deductible Waived	$0 Deductible Waived
X-Rays	$0	$0	$0 Deductible Waived	$0 Deductible Waived
BASIC RESTORATIVE	Co-Pay	Co-Pay	Co-Insurance	Co-Insurance
Office Visit	$5	*$10*	0%*	0%*
Sealant (to age 19)	$12/tooth	*$15/tooth*	20%	20%
Filings	*$13-$30 (amalgam)*	*$20-$45 (amalgam)*	20%	20%
Extractions	*$55 (single)*	*$20 (single)*	20%	20%
Periodontal Gingivectomy	*$225 Per Quadrant*	*$150 Per Quadrant*	20%	20%
Oral Surgery	*$55-$120*	*$20-$135*	20%	20%
MAJOR RESTORATIVE				
Office Visit	$5	*$10*	50%*	50%*
Crowns	*$280 + Lab*	*$265 + Lab*	50%	50%
Dentures	*$325 + Lab*	*$365 + Lab*	50%	50%
Fixed Bridgework	*$280+ Lab*	*$305 + Lab*	50%	50%
Crown/Bridge Repair	*$5 + Lab*	*$25*	50%	50%
Inlays	*$135-$170*	*$230-$305 + Lab*	50%	50%
ORTHODONTIA				
Child	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50%	50%
Adult	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50%	50%
TMJ Services				
Exam, services, etc.	Up to 25% of normal fees	Up to 25% of normal fees	No coverage	No coverage
MAXIMUM BENEFITS				
Annual combined preventive, basic, and major services	No dollar limit	No dollar limit	$2,000/person	$2,000/person
Orthodontia Lifetime	No dollar limit	No dollar limit	$1,500/person	$1,500/person

**Office visit and exams of any type are covered only two times a year at 100%.*

This is a Summary only; please see Plan Descriptions for detailed provisions.

HOW TO USE YOUR VISION PLAN

Coverage for vision examinations and corrective eyewear is available through Avesis, Incorporated. Retirees are responsible for the full premium cost of this voluntary plan for themselves and their dependents.

You may receive services from either a participating or a non-participating provider *once per plan year*. Exceptions are the LASIK benefit which is available one time only and only with a participating LASIK center, and additional eyewear benefit which you may use as many times as you wish with a discount within a participating provider's office

Participating Provider
To find a participating provider, either go online to *www.avesis.com* or call Avesis customer service at 1.800.828.9341. Then call the provider and identify yourself as an Avesis member and schedule your appointment. You can choose to receive your services from a participating optometrist, ophthalmologist or selected retail chain stores.

Participating Provider Fee Schedule	Co-pay	Allowance Given to Employee
1) Vision examination and **one** of the following:	$10	
a) Single, bifocal, trifocal, or lenticular lenses and frame		$100 - $150 allowance
b) Contact Lens*		$130 allowance
c) LASIK Surgery		$150 allowance
2) Options (E.g. Progressive lens, tinting, coatings, transitional lens)		20% discount from provider's fee

* Contact lenses would be covered in full if considered medically necessary.

Non-participating Provider
If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and include your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services. An out-of-network reimbursement form is available by visiting the Avesis website at *www.avesis.com*.

Non-Participating Provider Fee Schedule	Employee is Reimbursed
Vision Examination	Up to $50
Single Vision Lenses	Up to $30
Bifocal Lenses	Up to $45
Trifocal Lenses	Up to $55
Lenticular Lenses	Up to $110
Progressive Lenses	Up to $45
Frames	Up to $50
Options (e.g. tinting, coatings)	No reimbursement
Contact Lens Benefit*	
Elective	$150
Medically Necessary	$300
LASIK Surgery	Not Covered

*Member may choose to receive one of the following within their plan period: 1) spectacle lenses and a frame, OR the contact lens benefit. The Contact Lens Benefit takes the place of the exam, lenses and frame within that plan period.

This is a brief description of your voluntary vision care plan available through Benefit Options. For a complete listing of covered services for this plan, please refer to the plan description located on the website, *www.benefitoptions.az.gov* or contact Avesis directly at 1.800.828.9341.

COBRA CONTINUATION OF COVERAGE NOTICE

What is COBRA coverage?
Federal law requires that most group health plans give retirees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the retiree covered under the group health plan and the covered retiree's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the State of Arizona group health insurance plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by the State of Arizona (the "State") under the Plan [i.e., medical, dental, vision and health care Flexible Spending Account (FSA)] and not to any other benefits offered by the State (such as life insurance, disability, or accidental death and dismemberment). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

How can you elect COBRA coverage?
To elect COBRA coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver by the date specified on the Election Form to the ADOA Benefits Office as indicated on the Election Form. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the retiree's spouse may elect COBRA coverage even if the retiree does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The retiree or the retiree's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical, dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable pre-existing

condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA under the Health Care FSA
COBRA coverage under the health care FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health care FSA by the covered retiree, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for health care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the health care FSA, if elected, will consist of the health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year, and COBRA coverage will terminate at the end of the Plan year. All qualified beneficiaries who were covered under the health care FSA will be covered together for health care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits Office (see “For More Information” section below).

Special Considerations in deciding whether to elect COBRA
In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA coverage may eliminate this gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How long will COBRA coverage last?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months

from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of a loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the Plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid-in-full on time,
- a qualified beneficiary becomes covered, after electing COBRA coverage under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage, or
- the State ceases to provide any group health plan for its employees; or
- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason (for example, the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage as in a case of fraud). You must notify the applicable carrier(s) (see "For More Information" section on page 50) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrators, insurance carriers and/or HMOs may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How can you extend the length of COBRA coverage?

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in

order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. (The period of COBRA care FSA cannot be extended beyond the end of the current Plan year under any circumstances).

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the applicable carrier(s) (see "For More Information" section on page 50) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date of which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" section).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier(s) of that fact within 30 days after the Social

Security Administration's determination.

COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the applicable carrier(s) (see "For More Information" section) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event;
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the ADOA Benefits Once requests it. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or leer from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to the ADOA Benefits Office at the addresses indicated below (see "For More Information" section).

If the above procedures are not followed or if the notice is not provided within the 60- day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

How much does COBRA coverage cost?
Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The

amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

When (and how) must payment for COBRA coverage be made?
If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the ADOA Benefits Office to confirm the correct amount of your first payment.

Monthly payments for COBRA coverage.
After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each coverage period for each month for each qualified beneficiary is shown in the notice you receive. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage) – it is your responsibility to pay your COBRA premiums on time.

Grace periods for monthly payments.
Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Your first payment for COBRA coverage should be sent to the following:

Note: Although initial payment is mailed to ADOA, payments must be made payable to the applicable for which you are electing coverage.

ADOA Benefits Office
100 N. 15th Avenue, Ste. 103
Phoenix, AZ 85007

Checks should be made payable to:

- UnitedHealthcare for any of the UHC plans
- Fiserv Health - Harrington Benefit Services for any of the following plans: Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson
- Dental premiums should be made payable to the dental carriers: Delta, MetLife, EDS or Assurant/Assurant
- Vision premiums should be made payable to Avesis
- Flexible Spending premiums should be made payable to ADOA/HITF

After the initial payment, your monthly payments will be sent to the individual administrator/ carrier. You will receive an invoice each month that will include the applicable address.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan. If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments made after the grace period will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries Children born to or placed for adoption with the covered retiree during COBRA coverage period.
A child born to, adopted by, or placed for adoption with a covered retiree during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered retiree is a qualified beneficiary, the covered retiree has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Alternative recipients under QMCSOs.
A child of the covered retiree who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the State during the covered retiree's period of employment with the State is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered retiree.

For more information
This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Benefits Office.

If you have any questions concerning the information in this notice or your rights to COBRA coverage, you should contact the following:

ADOA Benefits Office
100 N. 15th Ave., Suite 103
Phoenix, AZ 85007

602.542.5008 or 800.304.3687
www.benefitsissues@azdoa.gov

Information about COBRA provisions for governmental employees is available from the:

Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

Or you may call 1.410.786.1565 for assistance. This is not a toll-free number. The CMS website is *www.cms.hhs.gov*.

Important Medicare Information

If you are eligible for Medicare Part B but do not enroll,

you will be financially liable

for all medical costs normally addressed by Part B.

These costs will not be paid by your ADOA Benefit Options Plan.

See the section “Medicare Part A & Part B Information” for details.

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We're committed to making health care simpler and more affordable for our members. When State of Arizona employees sign up for UnitedHealthcare's EPO plan, they get support and services that can help them take charge of their medical care and build a healthier lifestyle.

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Walgreens Health Initiatives

Your Pharmacy Benefit Is Designed to Save You Money

As a member of the State of Arizona Benefit Options' pharmacy benefit plan, administered by Walgreens Health Initiatives, there are two ways for you to save money on your maintenance medications (for long-term conditions).

1) Walgreens Mail Service = Lower copays
Save money by paying a lower copay for a 90-day supply instead of three, 30-day supplies at your retail pharmacy. Plus, Walgreens Mail Service is convenient!

- Standard shipping is free
- Orders are shipped right to your door in confidential, tamper-evident packaging
- Three easy ways to order: online, by mail, or by phone

2) Generic medications = Increased savings
Copays for generic medications—FDA-approved, chemically identical versions of brand-name medications—are generally less than for brand-name medications.

If you have any questions about using Walgreens Mail Service or generics, please log on to MyWHI.com. You can check copays, find generic alternatives, order mail service refills, and more. Or call our Customer Care Center toll free, 24 hours a day, seven days a week at **866-722-2141.**

Assurant Employee Benefits is pleased to offer the State of Arizona the Heritage Plus Prepaid plan

The Heritage Prepaid plan includes:

- Fixed copayment schedule for Plan Dentist services
- No claim forms for Plan Dentist and Plan Specialist services
- Each family member may choose a different dentist
- No annual deductible
- No annual maximum for Plan Dentist and Plan Specialist services
- No referral needed to see a Specialist
- An affordable Dental plan option for you and your family

Be sure to review your dental plan options closely.

Customer Services: 800.443.2995

Products and services marketed by Assurant Employee Benefits are provided by United Dental Care of Arizona, Inc. Plan limitations and exclusions apply.

ASSURANT
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WE GIVE ARIZONA'S STATE EMPLOYEES A REASON TO FLASH THEIR

PEARLY WHITES.

Whether it's Delta Dental's extensive roster of dentists located all over the state, or our friendly, local service with less paperwork, more people choose Delta Dental than any other dental plan. It's no wonder that Arizona's No. 1* dental plan is also the dental plan chosen by more State Employees. Find out what your co-workers are smiling about by visiting **www.deltadentalaz.com.**

DELTA DENTAL®

Celebrating 35 years of healthy smiles in Arizona.

Number 1 according to the 2007 Arizona Woman Who's Who in Business, Ranking Arizona, and Business Journal Book of Lists.

Employers Dental Services
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- No Deductibles
- No Claim Forms
- No Yearly Maximums
- No Waiting Period for Major Procedures
- Pre-Existing Conditions Covered (except procedures in progress)
- Customer Service Based in Arizona
- Worldwide Emergency Benefit 24 Hours a Day

BASIC SERVICES

Office Visit	$5.00
Routine Cleaning	$7.00
Amalgam (silver-colored) Fillings	$13.00 - $30.00

ADDITIONAL BENEFITS

- Orthodontic Care for Children & Adults
- Prescription Program
- TMJ Treatment Provided at a Discount
- Specialty Care Provided at a Discount

Employers Dental Services

A company of the Principal Financial Group

For additional information please call Customer Service at: 1-800-722-9772

Is Your Dental Care Complete?

Now you can plan for unexpected dental care costs with a dental benefits program from MetLife!

Now you have more reasons to smile with these valuable features:

Freedom of choice: Freedom to visit any dentist whether or not he/she participates in the MetLife Preferred Dentist Program (PDP). Plus, you don't need to pre-select a primary dentist or obtain referrals to see a specialist.

Broad network access: Access to a seamless national network of over 100,000 participating MetLife PDP dentist locations including nearly 22,000 specialty locations. And all participating dentists must pass MetLife's rigorous selection criteria.

Lower costs: Typically save 10% to 35% below the average fees of dentists in your area when you visit one of MetLife's nationwide network of participating dentists who agree to accept scheduled fees as payment-in-full for services rendered.

Benefits with savings and more value: Dental coverage with lower costs for covered services as well as non-covered services.* Plus, access to educational tools and resources and pre-treatment estimates — all with service you can trust!

Join us and see what everyone is smiling about!

*Savings from enrolling in a dental benefits plan will depend on various factors, including how often participants visit the dentist and the cost of services covered.

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